Improving Healthcare for Mental Health Patients: Is Collaborative Care the Answer?

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Medical Director of the Community Treatment Team
Mercy Behavioral Health, Pittsburgh, PA

Featured Collaborative Care Programs
Cheen Lum, PharmD, BCPP, Gallahue CMHC
Kathy Gonzalez, RN, The Psych Nurse Community Outreach Program
Speaker Profile

Rebecca Roma, MD, MBA

Position: Dr. Roma serves as the Medical Director of the Community Treatment Team at Mercy Behavioral Health in Pittsburgh, PA.

Education: Dr. Roma earned her MBA from the University of Pittsburgh, and earned her PhD in Economics and Market Research at Indiana University, prior to receiving her MD from the University of Pittsburgh School of Medicine. Dr. Roma completed her residency training at the Western Psychiatric Institute and Clinic of UPMC in Pittsburgh, PA.
Discussant Profiles

Kathy Gonzalez, RN

**Position:** Ms. Gonzalez is the founding partner of The Psych Nurse, from the Psych Nurse Community Outreach Program in San Juan, Texas.

**Education:** Ms. Gonzalez received her Associates Degree in Nursing from the University of Texas at Brownsville.

Cheen Lum, PharmD, BCPP

**Position:** Dr. Lum is a Board Certified Clinical Pharmacist Specialist-Psychiatry/Ambulatory Care at Gallahue CMHC Community Health Network in Indianapolis, Indiana.

**Education:** Dr. Lum received his Bachelor of Science degree in Pharmacy from Butler University and received his Doctor of Pharmacy degree from the University of Florida, Gainesville.
This program was developed with the support of Otsuka Pharmaceutical Development & Commercialization, Inc. and Lundbeck, LLC. The speakers are employees or compensated contractors of Otsuka Pharmaceutical Development & Commercialization, Inc.
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OPDC/Lundbeck’s interaction with OPEN MINDS is through PsychU, an online, non-branded portal dedicated to providing information and resources on important disease state and care delivery topics related to mental illness. One of the methods employed for the sharing of information will be the hosting of virtual fora. Virtual fora conducted by OPDC/Lundbeck are based on the following parameters:

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Objectives

- Highlight the risk of physical health disorders in patients with mental health disorders
- Review the concept, need, and outcomes of collaborative care
- Highlight 3 collaborative care model programs
- Discuss collaborative care opportunities, challenges, and lessons learned
MENTAL ILLNESS AND MORTALITY
Mortality and Mental Illness

• Patients with mental disorders have increased risks of morbidity and mortality compared with the general population\textsuperscript{1}
  – Major Depressive Disorder\textsuperscript{2}:
    • Patients with depression die 5 to 10 years earlier than those without depression
  – Bipolar Disorder\textsuperscript{3}:
    • Life expectancy is estimated to be reduced by approximately 10 years in men and 11 years in women
  – Schizophrenia\textsuperscript{3}:
    • Men with schizophrenia die 20 years earlier and women die 15 years earlier than the general population

Economic Burden of Mental Illness in the US¹-³

Mental illness imposes a substantial economic burden on individuals and society

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Dollars (in billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depressive Disorder</td>
<td>$210.5 (2010 USD)</td>
</tr>
<tr>
<td>Bipolar Disorder I/II</td>
<td>$151 (2009 USD)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>$155.7 (2013 USD)</td>
</tr>
</tbody>
</table>

US, United States; USD, United States dollars.

People With Behavioral Health & Substance Abuse Disorders Have High Utilization of Services

**Hospital Readmission Within 30 Days of Discharge (2012)**:

- **15.7%** Of initial inpatient (IP) stays for schizophrenia (SZ) were readmitted with a diagnosis of SZ
- **9.0%** Of initial IP stays for mood disorders were readmitted with a diagnosis of mood disorder
- **3.8%** Of initial IP stays for non-behavioral health disorders were readmitted for the same condition

### 2012 Annual Per Capita Admission Rates, Medicaid Population

<table>
<thead>
<tr>
<th>Condition</th>
<th>No MH/SUD</th>
<th>MH</th>
<th>SUD</th>
<th>MH and SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma &amp; Or COPD</td>
<td>0.42</td>
<td>0.65</td>
<td>1.25</td>
<td>1.91</td>
</tr>
<tr>
<td>CHF</td>
<td>0.92</td>
<td>1.39</td>
<td>1.97</td>
<td>2.96</td>
</tr>
<tr>
<td>CHD</td>
<td>0.47</td>
<td>0.68</td>
<td>1.33</td>
<td>1.97</td>
</tr>
<tr>
<td>Diabetes</td>
<td>0.4</td>
<td>0.68</td>
<td>1.38</td>
<td>2.12</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.34</td>
<td>0.58</td>
<td>1.22</td>
<td>1.94</td>
</tr>
</tbody>
</table>

CHD, coronary heart disease; CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; MH, mental health; SUD, substance use disorder.

WHY IS THERE A NEED FOR COLLABORATIVE CARE?
Lexicon for Integrated Care

Adapted from: Peek, CJ - A family tree of related terms used in behavioral health and primary care integration

Is the Current Behavioral Health Care System Fragmented?¹

Both mental and physical health providers administer mental health services often without much cross-exposure

Care coordination can be difficult due to differences in treatment practices, care delivery models, and communication protocols

Mental and physical health services are typically reimbursed separately

- Mental health coverage is either carved out of the majority of health plans or segmented out to a different set of providers
- This inhibits seamless care provision because payers looking to control health expenditures must deal with 2 different entities

Integrated Mental and Physical Healthcare

- Benefits of integrated mental and physical healthcare:

  67% with a BHD do not get behavioral health treatment

  50% of all BHDs are treated in primary care

  Two-thirds of PCPs report not being able to access outpatient behavioral health for their patients

  30% to 50% of patient referrals from primary care to an outpatient behavioral health clinic do not make the first appointment

  48% of appointments for psychotropic agents are with PCPs

BHD, behavioral health disorder; PCP, primary care physician.

Depression and Primary Care

• The primary care sector is becoming the de facto treatment setting for depression\textsuperscript{1}:
  – It is estimated that patients with depression constitute 5% to 10% of patients seen in primary care clinics
  – Nearly 60% of patients treated for depression in the United States receive treatment in a primary care setting
  – Primary care providers prescribe 79% of antidepressant medications

• Effective treatment in a primary care setting can be impacted by many factors, including\textsuperscript{1}:
  – The physician’s attitude and comfort in discussing mental health issues
  – Competing demands on the treating physician
  – Patient-specific factors (aversion to treatment, adherence, etc.)

• Inadequate treatment of depression negatively impacts interpersonal and family relationships, employment, and quality of life\textsuperscript{2}

COLLABORATIVE CARE MODELS
Advancing Integrated Mental Health Solutions (AIMS)

• The AIMS Center was created to help organizations develop collaborative care in the management of patients with depression and comorbid medical conditions

Potential elements for depression care:

• AIMS identified the following 5 important elements for effective, evidence-based depression care

1. Collaborative care
2. Depression care managers
3. Designated psychiatrists
4. Outcome measurement
5. Stepped care

Collaborative Care Model

Collaborative care is an approach to care that may include the following¹:

• Care manager works with the patient and the PCP to help develop a unified approach to care of the patient

• Patient education and support, including goals and a specific action plan

• Monitoring of treatment adherence and outcomes:
  – Cases are identified and patient progress is monitored through the use of instrument screening²

• Coordinating office visits to a PCP and/or a mental health specialist

PCP, primary care physician.

Advancing Integrated Mental Health Solutions (AIMS) Collaborative Care Team Structure

IMPACT$^{1,2}$

- The IMPACT (Improving Mood: Providing Access to Collaborative Treatment) study focused on collaborative care in adults with MDD >60yr/old ($n=1801$)

- IMPACT intervention gained access to a depression care manager, supervised by a psychiatrist and a PCP

MDD, major depressive disorder; PCP, primary care physician.

Mercy Behavioral Health Program

- **Certified Community Behavioral Health Clinic**
  - Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 supports states in establishing **certified community behavioral health clinics (CCBHCs)** through the creation and evaluation of a CCBHC 223 Demonstration Program.
  - States are selected to participate in a 2-year demonstration project (prospective payment rate system). Pennsylvania was one of 8 states chosen to participate.
  - The primary objective of the CCBHC demonstration is to improve behavioral health outcomes for targeted populations through innovation and transformation of the way primary and behavioral health care is delivered.
  - CCBHC program objectives also include the integration of behavioral health with physical health care, increasing consistent use of evidence-based practice, improving access to high-quality care and demonstrating cost efficiency.
COLLABORATIVE CARE OUTCOMES
Collaborative Care vs Usual Care in Depression

- A systematic review of 79 randomized controlled trials of depression or anxiety found that collaborative care was more effective than usual care in terms of\(^1\):
  - Depression outcomes
  - Antidepressant use
  - Mental health quality of life
  - Physical health quality of life
  - Patient satisfaction post-intervention

- A study evaluating a primary-care–based, collaborative-care intervention for depression and chronic illness reported improved depression and medical outcomes (eg, cholesterol, blood pressure) compared with usual care\(^2\)

- A survey assessing attitude after implementation of collaborative care in primary practice reported improved perceptions regarding burden of time required for depression care\(^3\):
  - Attributed to support provided by care manager
  - Use of a screening tool (Patient Health Questionnaire-9 [PHQ-9]) was identified as assisting in communication

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IMPACT Improves Outcomes, Saves Money*

12-Month depression response rate

% Patients

Usual care | IMPACT
---|---
0% | 50%
10% | 40%
20% |
30% |
40% |
50% |

4-Year healthcare costs**

Total cost, $

Usual care | IMPACT
---|---
$0 | $40,000
$10,000 |
$20,000 |
$30,000 |
$40,000 |

IMPACT, Improving Mood: Providing Access to Collaborative Treatment.

* In a geriatric population
** Includes intervention costs

THE MERCY BEHAVIORAL HEALTH EXPERIENCE
INTERVIEWS
The Psych Nurse

Kathy Gonzalez, RN; Founding Partner

• The Psych Nurse (TPN) is a community outreach program that provides care for mentally ill patients needing individualized attention. TPN consists of a team of nurses trained to implement a hands-on relationship-centric approach to managing symptoms of mental illness, as well patients’ diverse challenges of daily living. TPN provides comprehensive mental health services including administering medication, performing mental health assessments, and addressing social, housing, and financial challenges. TPN collaborates with patients and families, managed care organizations, and home health companies.

Interviewed by: Kamila Piekos, Pharm.D., Sr. Medical Science Liaison, OPDC

Source: www.thepsychnurse.com
Cheen Lum, PharmD, BCPP

- Medication management and collaborative pharmacy practice by a Board Certified Psychiatric Pharmacist (BCPP) in an inpatient and outpatient behavioral health setting, improving transition of care as well as medical and mental health for patients

- Key Results
  - Reduced recidivism
  - Reduced costs
  - Training new residents, both MD and PharmD, in collaboration to improve patient care

Interviewed by: Gwen Morris, PhD, Sr. Medical Science Liaison, OPDC
CHALLENGES TO IMPLEMENTING COLLABORATIVE CARE PROGRAMS
Challenges to Collaborative Care

- **Clinical**¹:
  - Patient reluctance to enroll
  - Low patient appointment attendance
  - Limited insurance coverage

- **Organizational**²:
  - Limits on the length of time providers can allocate to addressing mental health concerns
  - Workforce shortages of professionals trained in evidence-based interventions
  - Information-sharing obstacles between PCPs and mental health specialists due to privacy protection laws

- **Financial**²:
  - Lack of reimbursement for mental health treatment (e.g., depression screening, psychiatric consultation, and care management)
  - Billing restrictions for same-day medical and mental health visits
  - Lower reimbursement rates for depression treatment compared with medical evaluation

PCP, primary care physician.

LESSONS LEARNED
Summary

- Mental illness is associated with increased risk of morbidity and mortality relative to the general population\(^1\)
- Collaborative care involves the coordination of PCPs, mental health specialists, and care managers\(^2\)
- Studies of collaborative care models such as IMPACT have reported improved outcomes and reduced costs in comparison to usual care\(^2-4\)
- Implementation of collaborative care can be difficult due to clinical, organizational, and financial constraints\(^5\)

IMPACT, Improving Mood: Providing Access to Collaborative Treatment; PCP, Primary Care Physician.

CLOSING
## Upcoming Virtual Fora*

<table>
<thead>
<tr>
<th>Event</th>
<th>Speaker(s)</th>
<th>Date</th>
<th>Time</th>
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| Dealing With Stigma In Mental Health: Are We Making Progress?        | • Patrick Corrigan, PsyD  
• Kent Alford, RN, BSN                               | Wednesday, May 10, 2017 | 12:00—1:00pm EST   |
| Integrated Care: Navigating The Evolving Health Care System In 2017  | • Sloan Manning, MD  
• Marla Moses, FNP, PMHNP  
• Clayton Chau, MD                      | Tuesday, May 16, 2017  | 12:00—1:00pm EST   |
| Looking Beyond Mood & Psychosis: A Focus On Neurocognition           | • Philip D. Harvey, PhD  
• Katherine Burdick, PhD                              | Wednesday, June 7, 2017 | 12:00—1:00pm EST   |
| Exploring Nonpharmacological Anti-Inflammatory Strategies In Mental Health: Connecting Science To Clinical Practice (Inflammation Part 2) | • Rakesh Jain, MD, MPH                                | Thursday, June 15, 2017  | 12:00—1:00pm EST   |

*Register for these programs at https://www.psychu.org/events/
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